Meeting Discussion Guide »»
December 10, 2012

With Notes from 12-10-12 Meeting in red italics

Alaska Health Care Commission

I. Brief Discussion of Framework & Context for Commission's Work

II. Public Comment Review & 2012 Report Finalization and Approval

III. Affordable Care Act Update

IV. Next Steps/Wrap-Up

Plans for Today

Framework/Context

AHCC Role & Guiding Principles

» Policy Study Group/Think Tank

- Not a Collaborative Partnership, where members bring resources and ability to change organizational policy to the table to share in effort toward common goal
- Not a Coalition of organizations and individuals interested in uniting voices to advocate for shared special interests

» Planning and Advisory Role – Not "Do'ers"

- Commission has no authority

» Proactive – Not Reactive

- Commission to develop its own policy recommendations
- Not commenting or taking positions on legislation, regulations (state or federal), or new policy initiatives
- Avoid succumbing to the "tyranny of the urgent" and missing big picture
- Unlike politicians, the Commission has the luxury of being able to take time to study and develop long range plans for the future

» General Policy Recommendations

- "50,000 ft-level, not 50 ft"
- Systems thinking and systemic issues
- Strategic vs. Tactical – "What", not "How"
- No Operational Recommendations

» Apolitical

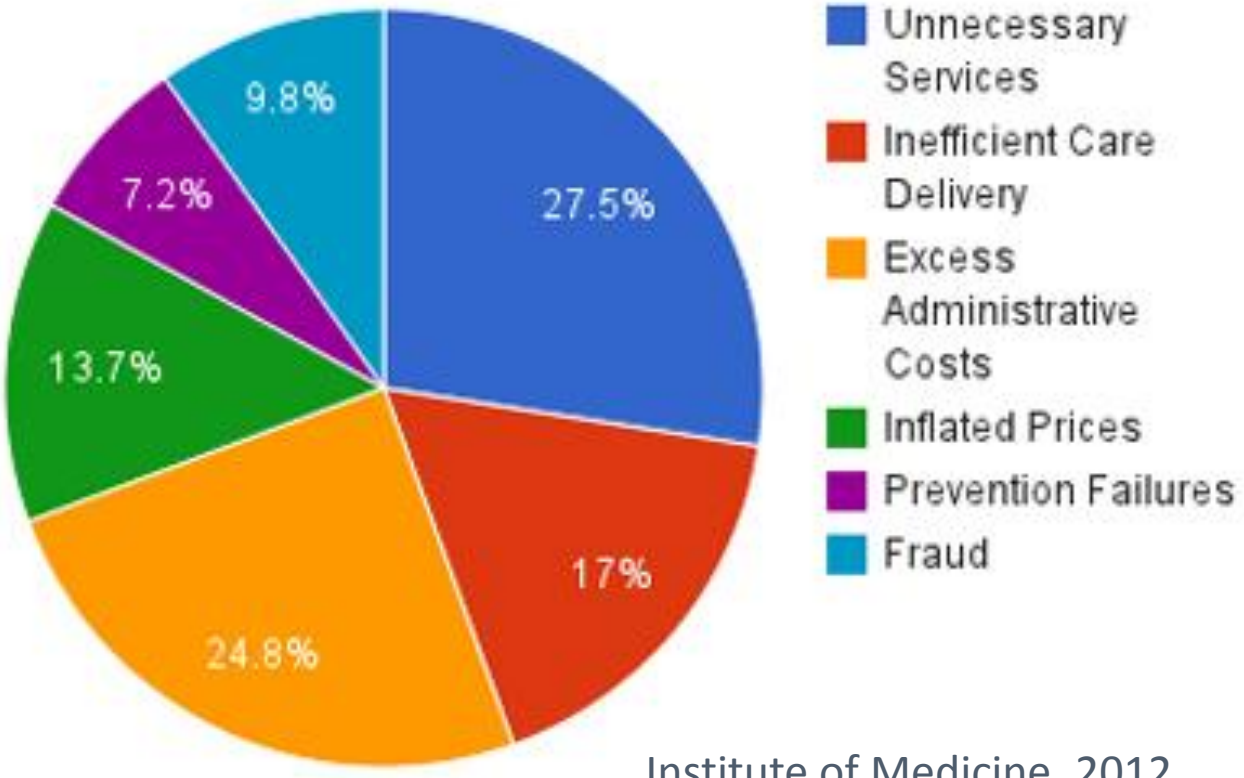
- Recommendations perceived as taking sides in the middle of political battles will not add value to the debate, and will divide and politicize the Commission

- Medical inflation continues to outpace CPI
  - the reason the Commission exists
- Acute medical care - largest component of health spending
  - >70% of all health spending
- State and Federal Government revenue and spending
  - Expect downward trend (potentially significant)
  - >60% of all health dollars spent
- Affordable Care Act

Biggest Bang for the Buck --- Cost of Acute Medical Care

Context

Sources of $750 Billion Annual Waste in U.S. Health Care System



Institute of Medicine, 2012

Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, September 6, 2012

Health Care Transformation Strategy

Design Policies to Enhance the Consumer's Role in Health

Through
- *Innovations in Patient-Centered Care*
- *Support for Healthy Lifestyles*

Build the Foundation
- *Statewide Leadership*
- *Sustainable Workforce*
- *Health Info Infrastructure*

To Achieve Goals of
- Increased **Value**
  - Decreased Cost
  - Increased Quality
- Improved **Access**
- **Healthy** Alaskans

Results: Community of Interest Survey (>1,500 AK respondents)

- Top 10 Health Concerns, in order of priority
  1. Alcohol use and abuse
  2. Cost of health care
  3. Diet, exercise and obesity
  4. Other substance abuse
  5. Violence
  6. Community safety
  7. Quality of life and well-being
  8. Sexual and reproductive practices
  9. Chronic disease related health outcomes
  10. Education

- Health Behaviors about which respondents were most concerned
  - Overweight and obesity 15.4%
  - Heavy drinking 9.6%
  - Illegal drug use 7.4%

- Access to Care factors about which respondents were most concerned
  - Ability to pay for health care 39.2%
  - Having a regular health care provider in your area 12.9%

Healthy Alaskans 2020

Public Comment Review & 2012 Report Revision/Approval

1. Vision, Goals, Definitions
2. 2012 Study of Current System Findings
3. 2013 Plans for Study of Current System
4. 2012 Strategies – Findings & Recommendations
5. 2013 Transformation Strategies

a) Changes Based on Public Comment?

b) Commission Changes?

c) Approve

Discussion Plan

- Vision, Definitions
- Pharmaceutical Cost Findings
- Behavioral Health Care
- 2013 Agenda – Study of Current System
- Telehealth Findings & Recommendations
- End-of-Life Care Findings & Recommendations
- Employers' Role Findings & Recommendations
- 2013 Agenda – Transformation Strategies
- Others

Comments Received

2012 Public Comments

- Vision, Definitions
  - Vision: Include current status/data for the 3 benchmarks (pg. 11, 48) *
  - Vision: Include 4th benchmark re: health disparities (pg. 30)
  - Def: Optimal health includes mental health & freedom from addiction (pg. 33)
  - Def: Health Care System omits other public providers (API; Corrections) (pg. 34)

* Page numbers reflect page # handwritten in upper right corner of each page in Public Comment Packet

AHCC's Vision

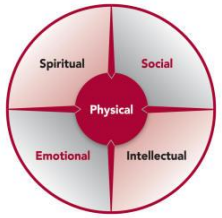
By 2025 Alaskans will be the healthiest people in the nation and have access to the highest quality, most affordable health care.

We will know we have attained this vision when, compared to the other 49 states, Alaskans have:

- *The highest life expectancy*
- *The highest percentage population with access to primary care*
- *The lowest per capita health care spending level*

Health & Healing

- Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health.



  - ***Physical:*** Fitness. Nutrition. Medical self-care. Control of substance abuse.
  - ***Emotional:*** Care for emotional crisis. Stress Management
  - ***Social:*** Communities. Families. Friends
  - ***Intellectual:*** Educational. Achievement. Career development
  - ***Spiritual:*** Love. Hope. Charity.

- An individual's health status is largely self-defined, encompassing a broader state of well-being beyond physical health and lack of disease or infirmity.

- Healing is restoration of wholeness and unity of body, mind and spirit. It involves curing when possible, but embraces more than cure. When illness is limited to disease and health care is limited to cure, the deeper dimensions of healing are missed.

AHCC's Definitions

Health Care System

- A health care system is a collection of organizations, practitioners and allied workers, facilities and technologies, financing mechanisms, policies, and information that provide and support the provision of health care for a population.

- People in Alaska obtain health care through three different systems: the private sector, the military/VA, and the Alaska Tribal Health System.

AHCC's Definitions

2012 Public Comments

- Pharmaceutical Cost Findings
  - Support federal S.319 (pg. 22)
  - Congress prohibits Medicare and Medicaid from going out to bid (pg. 22)
  - Suggested clarifying and contextual changes and additions
- Government Regulation
  - No comments
- Medical Malpractice
  - No comments
  - Clarifying edit suggestion

Hurlburt moved to accept noted changes; Branco 2nd'd; unanimous vote to approve

» Prices for pharmaceuticals do not appear to be a significant driver of higher health care costs in Alaska relative to the comparison states of Idaho, Washington, Oregon, Wyoming, and North Dakota.*

» Worker's Compensation payment rates for pharmaceuticals are higher in Alaska than the average of the Worker Compensation rates of the comparison states by approximately 17%.

Keller requested info noting volume by payer type be included for context.

» Medicare and Medicaid dispensing fees for Alaska are higher than Medicare and Medicaid dispensing fees in all the comparison states.

» There is significant variation in reimbursement levels between payers within Alaska. For example, Medicaid pays 15% more on average than the all-payer average within Alaska, while TRICARE pays 7% less on average.

» Price, while similar in Alaska on average relative to comparison states, and utilization of pharmaceuticals are critically important factors to consider in containing cost growth and improving quality of care and health outcomes.

* Milliman, Inc., *Pharmaceutical Reimbursement in Alaska and Comparison States*, October 16, 2012.

✓2012 Drug Price Findings

- The regulatory environment within which the health care industry operates is significant and complex. Extensive federal, state and local government policies affect such things as licensure and certification of health care workers and facilities, staffing requirements, allowable costs and services, prices for services, ownership and development of facilities, privacy and security of information, and business practices and relationships.

- Government regulation of health care impacts the cost to providers of delivering health care services, the prices paid by purchasers of health care, access to services, and quality and safety of services.

✓2012 Gov't Regulation Findings

Pg. 10-11 Public Comment DRAFT

- The federal regulatory environment impacting the financing and delivery of health care includes (but is not limited to) the following federal laws and their implementing regulations:
  - SSA – Social Security Act (Medicare and Medicaid laws)
  - PPACA – Patient Protection & Affordable Care Act
  - ARRA/HITECH – American Recovery & Reinvestment Act/Health Information Technology & Clinical Health Act
  - ERISA – Employee Retirement Income Security Act
  - COBRA – Consolidated Omnibus Budget Reconciliation Act
  - HIPAA – Health Insurance Portability and Accountability Act
  - EMTALA – Emergency Medical Treatment and Active Labor Act
  - MHPAEA – Mental Health Parity and Addiction Equity Act
  - ADA – Americans with Disability Act
  - FDA – Food and Drugs Act
  - GINA – Genetic Information Nondiscrimination Act
  - FSHCAA – Federally Supported Health Centers Assistance Act
  - IHCIA – Indian Health Care Improvement Act
  - FTCA – Federal Tort Claims Act
  - Antitrust Laws (including the Sherman, Clayton, and Federal Trade Commission Acts)
  - Tax Laws
  - Labor Laws

✓2012 Gov't Regulation Findings

Pg. 10-11 Public Comment DRAFT

» The State regulatory environment impacting the financing and delivery of health care includes (but is not limited to) the State Constitution and laws and regulations addressing:

- the private insurance market
- the Medicaid program
- provider licensure and certification
- facility certification
- the Certificate of Need program
- the Workers' Compensation program
- public health functions and programs
- civil legal procedure

✓2012 Gov't Regulation Findings

Pg. 10-11 Public Comment DRAFT

» Regulation of the private health insurance market is predominantly a state government function.

- State of Alaska insurance laws and regulations apply only to the private insurance market. Excluded are:
  - + Public insurance programs (Medicare and Medicaid)
  - + Federal and tribal health care delivery systems (DOD, VA, Indian Health Service, Tribal Health System)
  - + Self-insured employer plans protected under ERISA
- Approximately 15% of Alaskans are members of private insurance market health plans regulated by the State of Alaska.
- Two examples of state insurance laws and regulations identified as potential contributors to higher prices for acute medical services in Alaska are:
  - + A state law that requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks.
  - + A state regulation requiring usual and customary charge payment to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges.

✓2012 Gov't Regulation Findings

Pg. 10-11 Public Comment DRAFT

- Alaska's medical malpractice environment is relatively stable, supported by:
  - The 1997 Alaska Tort Reform Act
  - The 2005 Alaska Medical Injury Compensation Reform Act
  - Alaska Civil Rule 82

- Clinicians in two of Alaska's three medical sectors, the Tribal Health System and the Department of Defense/Veterans Affairs, are covered for medical liability under the Federal Tort Claims Act (FTCA) and are not subject to state tort law when acting within the scope of their official duties.

- Alaska's malpractice reforms to-date appear to have made an impact on the cost of medical liability coverage for Alaska's private medical sector.
  - In 1996 medical professional liability rates for physicians in Alaska were approximately two times those in northern California (considered the "gold standard" in liability reform)
  - Today, in 2012, Alaska's medical liability costs are in line with those in northern California.

- Alaskan health care administrators report anecdotally a positive impact on physician recruitment due to the positive malpractice environment in the state.

✓2012 Med Mal Reform Findings

Branco moved changes; Harrell 2nd'd; passed unanimously

» Cost savings associated with defensive medicine practices are more difficult to identify ~~as~~ because there are other contributors to these practices beyond the threat of litigation. ~~, for example,~~ Other factors that may influence defensive medicine practices include physician training and culture, fee-for-service reimbursement structures, and financing mechanisms that insulate patients from the cost of health care services.

✓2012 Med Mal Reform Findings

2012 Public Comments

- Behavioral Health Care
  - Insufficient attention (pg. 8, 33, 50)
- 2013 Agenda – Study of Current System
  - Oppose SNF Cost Comparison (pg. 24-26)
  - Shift from tracking federal reform to more active role (pg. 26)

» Current HC System Challenges for Study in 2013

Ward moved deletion of SNF study; Branco 2nd'd; passed unanimously

- ~~**Cost of Skilled Nursing Facility Care in Alaska:** Complete actuarial analysis comparing pricing and reimbursement levels for acute medical services in Alaska with comparison states, and identifying drivers of cost differentials:~~
  - ~~Skilled Nursing Facility (SNF) care as the last component of acute medical services (to complement earlier studies of the other acute medical service components: Physician and Hospital Services, Durable Medical Equipment, and Pharmaceuticals).~~

Campbell moved addition of Health Insurance Costs, Health Care Accounting, Hospital Readmission Rates, and Oral Health/Dental Services to 2013 Study Plans; Urata 2nd'd; passed unanimously

- **Health Insurance Costs and Cost Drivers (Reserve issue, MLR, etc)**
- **Health Care Accounting and Pricing – How it works**
- **Hospital Readmission Rates**
- **Oral Health & Dental Services**
- **Federal Reform:** Continue to track Affordable Care Act implementation activities in Alaska.

✓2013 Plans

2012 Public Comments

- Telehealth
  - Emphasis on telehealth is good (pg. 6, 8, 13, 34, 38, 41, 50)
  - Don't view it as "the solution" – reword: telehealth "compliments" system (pg. 6)
  - AeHN cannot take on additional role right now – re: Rec #2 (pg. 27)
  - Current reimbursement structure limits access to behavioral health (pg. 34)
  - As use of telemedicine increases problems must be monitored and providers properly trained (pg. 37)
  - Telehealth licensure not a problem for nurses (pg. 37)
  - Continue investigation of reimbursement and licensure issues (pg. 41)
  - Minor grammatical improvement edits from Deb

- Alaskan health care providers have been pioneers and global leaders in the use of telecommunications technologies as a mechanism for enhancing access to health care and improving clinical outcomes.

- Challenges to the continued development and use of telehealth technologies in Alaska include:
  - "Silos" between health care sectors and between payers and providers. There is not a unified approach to identification of telehealth needs, goals, and barriers nor to design of telehealth solutions.
    - Some collaboration has occurred between the military, VA and tribal health system under the auspices of the Alaska Federal Health Care Partnership, but there has been minimal collaboration between the federal and private health care sectors.
    - There has also been some very limited collaboration between payers and providers, e.g., the state Medicaid program and the tribal health system, and certain commercial insurance carriers and private sector hospitals.
    - There has been no collaboration between public and private insurance programs.
  - Misalignment of payment systems between costs and benefits. Savings achieved through the use of telemedicine do not always accrue to the providers who must invest in the technological infrastructure. Reimbursement has been restructured somewhat in recent years to support funding of "presenting" site providers, but there is evidence these reimbursement opportunities are not fully utilized by providers. Questions remain, such as:
    - Are existing reimbursement mechanisms fully utilized, and if not, why not? Is under-billing the result of inadequate documentation by clinicians, insufficient training for coders, or other billing issues?
    - Can new reimbursement mechanisms be justified? Are costs and savings clearly identified and documented?
  - The use of telehealth technology is not coordinated. There are currently multiple telehealth networks operating in Alaska, a variety of equipment and software applications in use, connectivity challenges due to limited bandwidth availability and technological variability, and no consolidated service endpoint index for maintaining the IP (Internet Protocol) addresses of devices used for telehealth purposes.
  - No mechanism for coordinating and scheduling patient encounters with telehealth providers exists.
  - Alaskan licensure is required for out-of-state clinicians serving patients in Alaska. No evidence has been presented that would indicate this poses a significant barrier to telehealth. If it is found to present a significant barrier at some point in the future the question regarding whether the patient-protection function served by state licensure outweighs the telehealth needs would have to be addressed.

✓2012 Telehealth Findings

Pg. 16-17 Public Comment DRAFT

- Opportunities exist and recent initiatives are underway that support further development and use of telehealth solutions, including:
  - The Statewide Health Information Exchange (a public-private partnership between the non-profit Alaska eHealth Network and the Alaska Department of Health & Social Services), which is facilitating private, secure communication between health care providers and will implement a platform for the sharing of medical records later this year.
  - The Connected Nation Program (in Alaska operating as a public-private partnership between the non-profit Connect Alaska and the Alaska Department of Commerce, Community and Economic Development), which is mapping community broadband access, and working to expand access, adoption and use of high-speed Internet capacity statewide.

Noted minor grammatical changes approved without a vote.

✓2012 Telehealth Findings

Pg. 16-17 Public Comment DRAFT

1. The Alaska Health Care Commission recommends the Department of Health & Social Services develop collaborative relationships across health care sectors and between payers and providers in existing telehealth initiatives to facilitate solutions to current access barriers. The Commission further recommends telehealth collaboratives:
   - Focus on increasing access to behavioral health and primary care services;
   - Target specific health conditions for which clinical improvement, health outcomes, costs and cost savings can be documented; and,
   - Include an evaluation plan and baseline measurements prior to implementation, measurable objectives and outcomes, and agreement between pilot partners on selected metrics.

Davidson moved the following changes; Urata 2nd'd (see next slide)

2. The Alaska Health Care Commission recommends the ~~Department of Health & Social Services direct the~~ Statewide Health Information Exchange entity (the Department of Health & Social Services) ~~to perform~~ develop a business use analysis for offering a statewide brokered telehealth service including:
   - Compilation and maintenance of a directory of telehealth providers
   - Compilation and maintenance of a directory of telehealth equipment addresses
   - Coordination of telehealth session scheduling for providers and equipment
   - Facilitation of network connections for telehealth sessions
   - Provision of 24/7 technical support

✓2012 Telehealth RECs

Friendly amendment offered by Hippler; passed unanimously:

2. The Alaska Health Care Commission recommends the Department of Health & Social Services ~~direct the Statewide Health Information Exchange entity to perform~~ develop a business use analysis for ~~offering~~ a private sector statewide brokered telehealth service including:
   - Compilation and maintenance of a directory of telehealth providers
   - Compilation and maintenance of a directory of telehealth equipment addresses
   - Coordination of telehealth session scheduling for providers and equipment
   - Facilitation of network connections for telehealth sessions
   - Provision of 24/7 technical support

Approved Wording:

2. The Alaska Health Care Commission recommends the Department of Health & Social Services develop a business use analysis for a private sector statewide brokered telehealth service including:
   - Compilation and maintenance of a directory of telehealth providers
   - Compilation and maintenance of a directory of telehealth equipment addresses
   - Coordination of telehealth session scheduling for providers and equipment
   - Facilitation of network connections for telehealth sessions
   - Provision of 24/7 technical support

✓2012 Telehealth RECs

» End-of-Life Care

- Supportive in general of this section (pg. 20, 37, 50-51)
- Supportive of evolving Comfort 1 to POLST/MOST (pg. 11, 50-51)
  - Don’t call the new program “POLST” (include non-doc clinicians) (pg. 37)
- Supportive of public education on this topic (pg. 11)
- Health Care education curriculum reform supported by UofA (pg. 16, 17)
- Clarifying edits to Findings Statements suggested (pg. 20-21, 37)
- Supportive of registry (pg. 34, 37, 50-51)
  - Include advance psychiatric directives in registry (pg. 34)

2012 Public Comments

* Page numbers reflect page # handwritten in upper right corner of each page in Public Comment Packet

- Any public policy discussion regarding end-of-life care must start with the ethical and spiritual dimension of this issue. Conversations and decisions regarding end-of-life care must be grounded in our common humanity and shared respect for human life.

- Alaskan patients who are seriously or terminally ill sometimes feel they are treated more like a battlefield than a person by the health care system. Quality of end-of-life care can be improved through:
  - Health care programs, practices and standards designed to fully engage patients and their families in understanding and decision-making regarding treatment and service options;
  - Engagement by all Alaskan adults in planning in advance and documenting medical, financial and other legal decisions for end-of-life circumstances.

✓2012 End-of-Life Findings

Pg. 18-19 Public Comment DRAFT

» Key concepts and definitions important for understanding end-of-life care:

- "Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Healing involves curing when possible, but embraces more than cure. When illness is limited to disease and health care is limited to cure, the deeper dimensions of healing are missed." Alaska Health Care Commission Definitions

- "When someone is diagnosed with a disease like cancer, a long journey begins. The disease or illness may be treated and go away. It may go away and come back. In some cases the disease cannot be cured and the patient gets sicker. While a patient's body is treated and cared for to reduce pain and other symptoms, it is also important to care for the whole person at all steps of the disease journey. Palliative care pays attention to the mind, body and spirit of the patient and family. It begins with the diagnosis of a life-limiting disease." Christine DeCourtney, *Palliative Care: Easing the Journey with Care, Comfort and Choices*, 2009

- "Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care though-out the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." 73 FR 32204, June 5, 2008

✓2012 End-of-Life Findings

Pg. 18-19 Public Comment DRAFT

Urata moved changes noted on this and following 2 slides; Branco 2nd'd; passed unanimously

» Key concepts and definitions important for understanding end-of-life care *(continued):*

- Hospice care is palliative care for ~~terminally ill patients~~ individuals approaching the end of ~~their~~ life and support for family and caregivers through the dying and grieving process. Hospice is ~~not~~ neither about slowing nor hastening death, but about providing compassionate care to ease dying, death and bereavement. Most hospice care is provided in the home setting.
  - + Hospice began as a movement in the 1970s to advance the philosophy that people have a right to die pain free and with dignity.
  - + Nationally, t~~T~~here are now examples of hospice organizations and hospice insurance benefits that support provision of and payment for palliative care for terminally ill patients.
  - ~~+ Some hospice organizations are certified by Medicare and must meet certain federal standards, and some hospice organizations are voluntary and have more flexibility in providing charity services but are limited in their ability to seek reimbursement from third-party payers.~~ Alaska regulations provide for licensing full-service hospices (which are essentially Medicare certified hospices) and volunteer hospices. Volunteer hospices are limited to services they can provide and are prohibited from seeking reimbursement for care.
  - + Medicare, Medicaid and private insurance payment policies for Hospice services vary, but generally require clinician documentation ~~regarding when the patient is likely to die~~ of life expectancy of six months or less, and does not allow curative treatment to be provided concurrent with hospice care.

- Research demonstrates that palliative care begun at the time of diagnosis of a terminal or serious illness or injury:
  - Improves the patient's experience through decreased pain, discomfort, and psychological distress;
  - Lengthens the patient's life span;
  - Increases patient and family quality of life;
  - Decreases inappropriate use of medical resources and results in cost savings to the health care system.;
  - Decreases adverse health outcomes for survivors.
- Health care system cost savings resulting from the use of palliative care and associated services, such as home health care, do not always accrue to the providing organization investing in and potentially subsidizing the services.
- Palliative care is not always reimbursable as a particular service by public and private third-party payers, but certain distinct services provided as a part of palliative care may be reimbursed, such as physician services, hospice services, and home health services. Current reimbursement methodologies do not recognize participation on the palliative care team by other essential providers such as social workers, chaplains, and care coordinators.

✓2012 End-of-Life Findings

Pg. 18-19 Public Comment DRAFT

- A number of states have implemented or are in the process of developing a statewide POLST Program. Physician Orders for Life-Sustaining Treatment (POLST) (alternately known as Medical Orders for Scope of Treatment (MOST)) is a standardized process designed to improve the quality of care for people who have advanced progressive illness and/or frailty.
  - POLST programs provide tools for translating a patient's health care goals into medical orders. Central components include clarification and communication of patient treatment goals and wishes, documentation in the form of medical orders on a standardized and recognizable form, and an obligation of health care professionals to honor these preferences across all care settings.
  - POLST is not a living will or advanced health care directive. The latter are intended to facilitate planning in advance of a serious illness or injury and to convey wishes in the event the patient is unable to communicate. POLST/MOST is for patients who have been diagnosed with a serious illness and are able to convey their wishes and participate as a partner in their health care team.

- Alaska established the Comfort One Program in state law in 1996 to help health care providers, the Medical Examiner and First Responders identify terminally ill people who have expressed a wish to not receive life- ~~saving~~prolonging measures, such as cardiopulmonary resuscitation (CPR), when they go into respiratory or cardiac arrest. Alaska's Comfort One program was based on Montana's Comfort One program, which has evolved in recent years to a POLST program. While Comfort One is primarily intended for communicating patient DNR (Do Not Resuscitate) orders to emergency medical service personnel, POLST applies to all medical providers and conveys patient wishes regarding a broader scope of medical procedures.

✓2012 End-of-Life Findings

Pg. 18-19 Public Comment DRAFT

1. The Alaska Health Care Commission recommends the Governor or legislature foster communication and education regarding end-of-life planning and health care for seriously and terminally ill patients by supporting a program to:
   a. Sponsor an on-going statewide public education campaign regarding the value of end-of-life planning; and,
   b. Establish and maintain a website for end-of-life planning and palliative care resources, including Alaska-specific information, planning guides, clinical best practices and practice guidelines, and educational opportunities for the general public and for clinicians and other community-based service providers.

1. The Alaska Health Care Commission recommends the Department of Commerce, Community, and Economic Development require within current continuing medical education guidelines education in end-of-life care, palliative care, and pain management for physicians and other state-licensed clinicians as a condition of licensure renewal.

3. The Alaska Health Care Commission recommends the University of Alaska ensure end-of-life care is included within the curriculum of health practitioner training programs.

4. The Alaska Health Care Commission recommends the Department of Health & Social Services fund a process to investigate evolving the Comfort One program to a POLST/MOST program (Physician Orders for Life Sustaining Treatment/Medical Orders for Scope of Treatment).

5. The Alaska Health Care Commission recommends the legislature establish a secure electronic registry aligned with the Statewide Health Information Exchange as a place for Alaskans to securely store directives associated with end-of-life and advanced health care plans online and to give authorized health care providers immediate access to them.

6. The Alaska Health Care Commission recommends the State of Alaska partner with other payers and providers to demonstrate:
   a. The use of telehealth technologies for delivering hospice and other palliative care services to rural and underserved urban Alaskans; and
   b. The design of new reimbursement methodologies that improve the value equation in financing of end-of-life services.

✓2012 End-of-Life RECs

- Employer's Role
  - Supportive in general (pg. 13)
  - Regarding All-Payer Claims Database
    - Supportive of database for public transparency purposes (pg. 13)
    - Form stakeholder group to plan APCD next steps (pg. 27-28)
  - Provide nurses and showers for public employees (pg. 23)
  - Health care industry is also an employer (pg. 28-29)
  - Be mindful of complexity and fragility of the health care system (especially rural), and also of unintended consequences (pg. 28-29)
  - Concern that consumer-directed health plans and co-insurance discourages necessary care (pg. 41)
  - State should counsel their own employees for Medicare enrollment and retirement (pg. 51)

2012 Public Comments

- Employers play an important role in the health of their employees, and in the value – the cost, quality and outcomes – of health care services purchased through employee health plans.
- CEOs who take control of health care like any other supply chain issue and adopt health and health care improvement as a business strategy are improving employee wellness and productivity, containing health care cost growth and improving health care quality for their companies.
- Essential elements of employee health management programs that demonstrate success in driving down health care costs and improving quality and employee health outcomes include:
  - **Price Sensitivity.** Traditional health plans with low deductible and co-payment requirements insulate the plan member/patient from experiencing the direct cost of a service; therefore there is little incentive for the covered patient to engage as an informed consumer and as a partner with their health care provider in addressing questions regarding the need, efficacy and price for a service. Consumer-driven health plans that include employer-supported Health Savings or Health Reimbursement Accounts, off-set by higher deductibles and co-insurance, engage members to shop for price, service and quality, and demonstrate cost savings.
  - **Price & Quality Transparency.** Employees/plan members must have easy access to information on the prices charged for health services, the amount their health plan will reimburse, and the quality of services available in order to be informed and engaged health care consumers.
  - **Pro-active Primary Care Emphasis.** Primary care must be easily accessible to employees in terms of physical location and convenience, and also in terms of low or no co-insurance costs. Preventive services, easy access to care for acute illness and minor injuries, and pro-active support for management of chronic conditions avoids more costly care that might otherwise require a higher level of care and also higher costs associated with later treatment of conditions that might worsen with time.
  - **Support for Healthy Lifestyles.** Employers' policies and working conditions can be designed to support an employee's ability to make healthy choices, and can also provide employees with incentives to improve and maintain their personal health.

✓2012 Employer's Role Findings

1. The Alaska Health Care Commission recommends the Department of Health & Social Services investigate and the legislature support implementation of a mechanism for providing the public with information on prices for health care services offered in the state, including information on how quality and outcomes compare, so Alaskans can make informed choices as engaged consumers.
   - To support this strategy the Commission is currently studying the business use case for a statewide All-Payer Claims Database for Alaska, and investigating health care price and quality transparency legislation enacted in other states.

2. The Alaska Health Care Commission recommends the State of Alaska, as a major employer in the state, play a leadership role for all Alaskan employers by continuing to develop and share strategies already underway to improve employee health and productivity and increase health care value. The Commission recommends the Department of Administration take a comprehensive approach by including all the essential elements of a successful employee health management program: Price sensitivity, price and quality transparency, pro-active primary care, and healthy life-style support for employees.
   - To support this strategy the Commission will continue to engage the business community and public employers in learning about opportunities for increasing value in health care and improving health outcomes.

✓2012 Employer's Role RECs

2012 Public Comments

- Workforce:
  - Loan repayment program reference positive (pg. 2)
  - Appreciate emphasis on "growing our own" (pg. 6)
  - Fed/State regulatory frustrations – CNA example (pg. 6; Attach A)
  - Supportive of Commission's interest in workforce (pg. 26-27)
  - More family med residencies are a good idea; residencies for internists – not so much. Need incentives for family med resident grads to live and practice in rural Alaska (pg. 11)
  - Questions about data and status of Workforce Coalition (pg. 13)
  - Medical school education should be 100% subsidized by government (pg. 23)
  - Strategies to increase primary care docs should include ANPs (pg. 36-37)
  - Osteopathic medical schools are important strategy for increasing primary care physician supply (pg. 44-47)
  - Continue efforts to build workforce for primary care, behavioral health, and geriatric care providers (pg. 50)

- Health Information Infrastructure
  - As use of EHRs increases problems must be monitored and providers properly trained (pg. 37)
- Evidence-Based Medicine
  - Supportive of promotion of EBM; apply to health care delivery models too; change terminology to “Evidence-Based Healthcare” (pg. 36)
  - Encourage EBM, but caution regarding over-application to uncommon conditions where research is very limited (pg. 41-42)
- Patient-Centered Medical Homes
  - Emphasize strategies to implement PCMH model (pg. 50)
- Medicare Access
  - State should track primary care access for Medicare beneficiaries (pg. 51)

2012 Public Comments

- Other
  - Health care cost concerns/focus (pg. 1, 4)
  - Insurance Exchange (pg. 1, 13)
  - Oral health (pg. 3)
  - Tools are available to support Medical Consumerism (pg. 4-5)
  - Special Populations:
    - Traumatic Brain Injury (pg. 10, 14-15, 18-19, 43, 52)
    - Persons with disabilities (pg. 38-39, 52)
    - Persons with Multiple Sclerosis (pg. 41)
    - Older Alaskans (pg. 49)
  - Tobacco and Obesity Control Tactics (pg. 22-23)
  - Increase home health care services (pg. 22-23)
  - Medicaid Expansion (pg. 26, 30-32)
  - Adolescent health care transition to adult clinicians and insurance (pg. 36)
  - Support prevention and population health (pg. 36)
  - Develop HC System scorecard for indicators/trends (pg. 48)
  - Consider community's role, not just the consumer's (pg. 48)
  - Study evidence-based practices to engage Alaskans in healthy lifestyles (pg. 48)
  - Consider PFD for health and wellness (pg. 48)
  - Alzheimer's Disease & Related Dementia (pg. 51)
  - Increase focus on wellness, holistic health, and self-care (pg. 52)
  - Integrative Medical Model is cost effective (pg. 52)

2012 Public Comments

» Transformation Strategies for Study in 2013

- **Design policies to enhance the consumer's role in health and health care - A) Innovate to improve quality, affordability and access to care:**
  - **Employer's Role in Health & Health Care – Employee Health Benefit and Plan Design:** Continue engagement with the business community and public employers regarding evolving business models to drive improved health, increased health care quality, and decreased health care costs.
  - **Price & Quality Transparency:** Consider final report from the Commission's All-Payer Claims Database consultants, inventory of transparency legislation from other states, and additional strategies for providing health care price and quality transparency.
  - **Evidence-Based Medicine:** Delve deeper into how state government policy should support the application of high grade evidence by patients, clinicians, and payers to improve value. Discuss the application of evidence-based medicine principles in insurance company policy (benefit design, pre-authorization, and utilization review).
  - **Track Developments in Alaska Related to Previous Recommendations:**
    - Evidence-Based Medicine
    - Value-Based Purchasing (Payment Reform)
    - Patient-Centered Primary Care
    - Trauma System
    - Price & Quality Transparency
    - Telehealth
    - End-of-Life Care
    - Employer's Role in Health & Health Care

✓2013 Plans ›

» Transformation Strategies for Study in 2013

- **Design policies to enhance the consumer's role in health and health care - B) Support Healthy Lifestyles**
  - **Employer's Role in Health & Health Care – Worksite Wellness:** Identify the roles Alaska's employers play in their employees' health and access to health care, and study innovative approaches employers in Alaska and across the country are utilizing to create cultures of wellness and promote the health and safety of their employees.
  - **Track Developments in Alaska Related to Previous Recommendations:**
    - Obesity
    - Immunizations
    - Behavioral Health
  - **Track Development of Healthy Alaskans 2020**

- **Build the foundation of a sustainable health system**
  - **Statewide Leadership:**
    - Identify indicators for measuring statewide health care delivery system improvement
  - **Sustainable, Innovative Health Workforce**
    - Track developments in Alaska related to previous recommendations
  - **Health Information Infrastructure**
    - Track developments in Alaska related to previous recommendations

✓2013 Plans ›

Affordable Care Act Update

- Presidential election Nov 6.
- Alaska (DHSS) one of four states awarded $1 million Elder Abuse Prevention Program cooperative agreement – Nov 1, 2012.
- Insurance Exchanges: HHS extended the deadline for states to submit letters of intent to establish a state-based exchange from Nov 16 to Dec 14. Blueprints are due Dec 14 from states that will operate their own exchange, and Feb 15 2013 from states that will partner in a federal exchange.
- Alaska enrollment in pre-existing conditions health plan as of Sept 30 (posted by HHS Nov 16): 45
- Federal regulations and guidance released since last meeting:
  - CMS released final regulations implementing higher Medicaid payments to primary care physicians – N/A in Alaska – (Nov 1)
  - Pre-existing Conditions Exclusion Prohibition (proposed regs released Nov 20)
  - Employment-based wellness programs (proposed regs released Nov 20)
    - Consumer protection (reasonable design, i.e., appropriate and equitable)
    - Increase in maximum permissible rewards
  - Policies & Standards for coverage of Essential Health Benefits (proposed regs released Nov 20)
  - CMS Guidance letter to State Medicaid Directors on Essential Health Benefits (Nov 20)
  - Multi-State Plans (proposed regs released Nov 30)

ACA Update

Wrap-Up/Next Steps

Potential 2013 Meeting Dates

- March
- May
- August
- October

Public Comment Period: November 1 – 29

- Week of December 9

Potential 2013 Meeting Dates